



Name _____ Date _____
Last First M
Male Female

Address _____ City _____ State _____ Zip _____
SS # _____ Birth Date _____

If full time student, School Name _____

Father's Name _____ Home # _____ Cell # _____
Birth Date _____ SS # _____

Place of employment _____ Work # _____

Mother's Name _____ Home # _____ Cell # _____
Birth Date _____ SS # _____

Place of employment _____ Work # _____

INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient _____

Birth Date _____ SS# _____ Date employed _____

Name of Employer _____

Insurance Company _____ Telephone # _____ Group # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Have you used any benefits for this benefit year? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? YES NO IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birth Date _____ SS# _____ Date employed _____

Name of Employer _____

Insurance Company _____ Telephone # _____ Group # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Have you used any benefits for this benefit year? _____

*Keep in mind that the docotr does not have a contract with the insurance company - you do. It is your responsibility to see that they pay on time.

SERVICE CHARGES

If I do not pat the entire balance within 25 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be periodic rate of 1.5% per month (or a minimum charge of \$3.00 for a balance under \$200.00) which is an annual percentage rate of 18% applied to that last month's balance. In the case of default of payment, I promise to pay any legal interest to the balance due, together with an collection costs, attorney's fees, and court incurred to effect collection of this account or future outstanding accounts.

AUTHORIZATIONS

I hereby authorize directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I Am responsible for all costs of the dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to my dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or health professional.

X
Adult Patient Father (or Husband) Mother (or Wife) Guardian Date

Primary reason for this dental appointment: Examination Emergency Consultation

Dental History

Please Circle

Do you have a specific dental problem? Describe _____ Yes No
 Do you have dental examinations on a routine basis? Last visit _____ Yes No
 Do you think you have active decay or gum disease? _____ Yes No
 Do you brush and floss on a routine basis? Discuss _____ Yes No
 Do your gums ever bleed? Discuss _____ Yes No
 Do you like your smile? Why? _____ Yes No
 Does food catch between your teeth? Any loose teeth? _____ Yes No
 Do you want to keep your remaining teeth? _____ Yes No
 Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____ Yes No
 Have your past experiences in a dental office always been positive? _____ Yes No
 Do you smoke or chew? Any sores or growths in your mouth? Discuss _____ Yes No
 Name of previous dentist (optional): _____
 Date of last full mouth x-rays (16 small films or panoramic): _____

Medical History

Are you under a physician's care now? Why? Who? _____ Yes No
 Have you ever been hospitalized or had a major operation? Discuss _____ Yes No
 Have you ever had a serious injury to your head or neck? Discuss _____ Yes No
 Are you taking any medications, pills or drugs? What? _____ Yes No
 Are you on a special diet? Discuss _____ Yes No

Are you allergic to any medications or substances? Please check box below

Aspirin Penicillin Codeine Acrylic Metal Latex Rubber Other _____

WOMAN (Please check): Pregnant/trying to get pregnant Nursing Taking oral contraceptives

***If yes to any of the starred conditions, please call prior to your appointment... Premedication may be required**

Heart Trouble/Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bruise Easily	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Yellow Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cold Sores	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Murmur*	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fever Blisters	<input type="checkbox"/> Yes <input type="checkbox"/> No
Irregular Heart Beat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Renal Dialysis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina/Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	X-Ray Treatments (Radiation)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Attack/Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia (Bleeding Problem)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parathyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Convulsions	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Leukemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach/Intestinal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis/Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy or Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Blood Transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of Limbs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Weight Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain in Jaw Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic Fever*	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cortisone Medicine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors or Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Breathing Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Artificial Joint*	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervousness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Pace Maker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Thirst	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Surgery*	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypoglycemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Alzheimer's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Allergies (Medicines)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis A (Infectious)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Genital Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Allergies (Pollen/Dust)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis B (Serum)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Drug Addiction	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hives or Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No

FEMALE PATIENTS: I have been advised that certain antibiotics commonly prescribed for dental conditions, may interfere with the reliability of oral contraceptives which may result in an unwanted pregnancy. _____

Have you ever had any other serious illness not checked above? Discuss _____ Yes No

Do you wish to talk to the dentist privately about any problem? _____ Yes No

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X _____ Date _____

Reviewed By Doctor _____ Date _____ BP _____

History Review and Significant Findings: _____

Medical Updates

I have read my MEDICAL HISTORY dated _____ and confirmed that it adequately states past and present conditions

DATE	EXCEPTIONS	PATIENT SIGNATURE	BP	REVIEWED BY
_____	NONE <input type="checkbox"/>	_____	_____	Dr. _____
_____	NONE <input type="checkbox"/>	_____	_____	Dr. _____
_____	NONE <input type="checkbox"/>	_____	_____	Dr. _____
_____	NONE <input type="checkbox"/>	_____	_____	Dr. _____

**Permission for Dental Examination and/or
Treatment of a minor**

I am the parent or guardian of _____
who is a minor child, and I do hereby authorize and consent to any x-ray, examination, anesthetic, sedative, or
dental treatment rendered under the general, direct, or indirect supervision of Dr. _____
and his/her associates, staff members, or agents, as he/she may deem necessary.

This authorization will remain in effect until cancelled in writing by me.

Parent Signature _____ Date _____

Witness _____

Thank you for choosing our office for your dental care. We will work with you to help you achieve excellent oral health. While recognizing the benefits of a pleasing smile and teeth that function well, you should be aware that dental treatment, like treatment of any other part of the body, has some inherent risks. These are seldom great enough to offset the benefits of treatment, but should be considered when making treatment choices.

Benefits of dental treatment can include: relief of pain, the ability to chew properly, and the confidence and social interaction that a pleasing smile can bring. Nonetheless, there are some common risks associated with virtually any dental procedure, including:

1. **Drug or chemical reaction.** Dental materials and medications may trigger allergic or sensitivity reactions.
2. **Long-term numbness (paresthesia).** Local anesthesia, or its administration, while almost always adequate to allow comfortable care, can result in transient, or in rare instances, permanent numbness.
3. **Muscle or joint tenderness.** Holding one's mouth open can result in muscle or jaw joint tenderness, or in a predisposed patient, precipitate a TMJ disorder.
4. **Sensitivity in teeth or gums, infection, or bleeding.**
5. **Swallowing or inhaling small objects.**

While we follow procedural guidelines which most often lead to a clinical success, just like in any other pursuit in health care, not everything turns out the way it is planned. We will do our best to assure that it does. Please feel free to ask questions in regard to all dental procedures that are recommended to you.

I have read and understand the statement on this page.

Patient's Signature

Date

Parent's Signature (if minor patient)

Date



Timothy Biel, D.D.S.
Dominic Toriggino, D.D.S.

Rodger Miller, D.D.S.
Neil Kruglet, D.D.S.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVATE PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

(Please Print Name)

(Signature)

(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment can not be obtained because:

- Individual refuses to sign
- Communication barrier prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

